MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

00377

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 2 mo 22 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs 2 mo 22 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nancy Adrian

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: Clement L. V. Adrian

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov 13th 1864

8. AGE: Years: 81 Months: 2 Days: 18 If less than one day: ..... hrs. ..... min.

9. Birthplace: Amity Ohio (Town, county, and state)

10. Usual occupation: School teacher

11. Industry or business:

FATHER 12. Name: John Nicholas

13. Birthplace: Amity Ohio

MOTHER 14. Maiden name: Mary Hummel

15. Birthplace:

16. Informant: Mrs A J Banks (Washington

Address: 2619 Lawrence St. N.W. DC

17. Burial, cremation, or removal. Which?: By train Date thereof: 1 (month) 31 (day) 46 (year)

Cemetery or crematory: Amity, Ohio

Location:

18. Funeral director: W.W. Chambers Co

Address: Riverdale, Md

19. Jan 31 1946 (Date rec'd by registrar) C. Harry Klein Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31st 1946, at 1-35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9th 1942 to Jan 31st 1946 and that I last saw her alive on Jan 30th 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 da
Due to: Arterio Sclerosis	6 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W H Wootton M.D. M. D. or other

Address: Sykesville Md Date signed 1/31/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00378

CERTIFICATE OF DEATH

★ Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos. 11 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 6 mos. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)

Street No. 8507 Greenwood Avenue (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Florence E. Albrecht

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William Albrecht 6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 10/6/1891

8. AGE: Years	Months	Days	If less than one day
54	3	22	...hrs. ...min.

9. Birthplace New Foundland (Town, county, and state)

10. Usual occupation ? Housewife

11. Industry or business

FATHER 12. Name Pettis

FATHER 13. Birthplace New Foundland

MOTHER 14. Maiden name Heather

MOTHER 15. Birthplace New Foundland

18. Informant William Albrecht

Address 8507 Greenwood Ave., Takoma Park

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 29, 1946 (month) (day) (year)

Cemetery or crematory

Location Washington, D. C.

18. Funeral director L. J. Gaffney

Address 425 N. C. Washington D. C.

19. Jan. 29 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29/46 19... at 3:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/18 19 45 to 1/29 19 46 and that I last saw h... alive on 1-28 19 46

Immediate cause of death	DURATION
Psychosis with Syphilitic Meningo-Encephalitis	Known May 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D. M. D. or other

Address Springfield State Hospital Sykesville, Maryland Date signed 1/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (80)

CERTIFICATE OF DEATH

06379

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs. 5 mo. 9 da.
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 16 yrs. 5 mo. 9 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Calvert
City or town: Prince Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY A. AVIDIAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: (Unknown) Avidian
Unknown 6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): February 21, 1888

8. AGE: Years	Months	Days	If less than one day
57	10	28	hrs. min.

9. Birthplace: Calvert County, Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none
FATHER 12. Name: William G. Cassard
13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Edith Powell
15. Birthplace: Calvert County, Maryland
16. Informant: Hospital Records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 24, 1946 (month) (day) (year)
Cemetery or crematory: St. Paul's Cemetery
Location: Mineral, Md.
18. Funeral director: A. R. Harkness
Address: Mineral, Md.
19. Jan. 22 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18, 1946, at 8.30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 1931, to Jan. 18 1946
and that I last saw her alive on Jan. 18 1946

Immediate cause of death	DURATION
Encephalitis (non epidemic)	17 yrs
Due to:	
Due to:	
Other conditions: Psychosis with Organic Broain Disease	17 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maud M. Rees M.D.
M. D. or other
Address: Sykesville, Md. Date signed: 1-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on

00380

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

FILM No. I 00 JAN 28 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years, 8 months

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 5 years, 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. /
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George Barrett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 15, 1908

8. AGE: Years	Months	Days	If less than one day
~~36~~ 37	1	6	hrs. min.

9. Birthplace: Wilmington, Delaware
(Town, county, and state)

10. Usual occupation: paperhanger

11. Industry or business:

FATHER — 12. Name: Allan E. Barrett
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Adeline Mellor
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 24 1946 (month) (day) (year)

Cemetery or crematory: St. Johns Cemetery

Location: Ellicott City, Md.

18. Funeral director: Easton Ford

Address: Ellicott City, Md.

19. Jan. 21 1946 (Date rec'd by registrar) C. Henry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21 19 46, at 5:15a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to Jan. 21 19 46 and that I last saw him alive on January 20 19 46

Immediate cause of death	DURATION
Bronchopneumonia	24 hours
Due to:	
Due to:	
Other conditions: Schizophrenia, paranoid type	8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 1-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122a)

CERTIFICATE OF DEATH

06381

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 1 day

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 month 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown -
(If outside city or town limits, write RURAL and give nearest town)

Street No. 63 Broadway -
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Samuel Edward Beeler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife Ruth Catherine Beeler

B.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) August 7 1876

8. AGE:

Years	Months	Days	If less than one day
69	5	6	...hrs. ...min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Mechanical Engineer

11. Industry or business

FATHER 12. Name Samuel Beeler

13. Birthplace Maryland

MOTHER 14. Maiden name Rachel Funkhauser

15. Birthplace Virginia

16. Informant Ruth B. Beeler

Address 63 Broadway, Hagerstown, Md -

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/46 (month) (day) (year)

Cemetery or crematory Rest Haven Cem

Location Hagerstown Md

18. Funeral director H. K. Coffman

Address Hagerstown Md.

19. Jan. 14 1946 C. Harry Zeek
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1946, at 12:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12 1945, to January 13 1946 and that I last saw him alive on January 13 1946

Immediate cause of death	DURATION
Acute Suppurative Nephritis and Pyelonephritis, Acute Cystitis Acute Peritonitis	Unknown
Due to (b)	
due to above (direct extension)	
Due to (c)	
Other conditions Psychosis with Cerebral Arteriosclerosis	Unknown 12-12-45

(Include pregnancy within 3 months of death)

Major findings of operations Herniotomy

Date of op. Jan 3 - 1946

Autopsy results As above -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beeler M.D.
M. D. or other

Address Sykesville, Md Date signed Jan. 13-46

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

06582

Reg. Dist. No. 80

1. PLACE OF DEATH:
County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Catherine Benedict

3.(b) Social Security Number: None

4. Sex: Female | 5. Color or race: white | 6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband ~~or wife~~: Samuel M. Benedict 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 12 - 1857

8. AGE: Years: 88 | Months: 7 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: William W. Smelser
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sophia Fisher
15. Birthplace: Maryland

16. Informant: Essie S. Benedict
Address: New Windsor, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Jan. 11-1946 (month) (day) (year)
Cemetery or crematory: Winters Cemetery
Location: New Windsor R. 2. Md.

18. Funeral director: H. H. Hartzler & Sons
Address: Union Bridge & New Windsor Md.

19. (Date rec'd by registrar) Jan 10 1946 Essie S. Benedict Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 8 1946 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1945 to January 8 1946 and that I last saw h.er alive on January 8 1946

	DURATION
Immediate cause of death: Bronchopneumonia	2 days
Due to: Generalized Arteriosclerosis	Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. T. Marsh M.D. M. D. or other
Address: Westminster Md. Date signed: 1/9/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

★ 00383

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yr., 6 mo., 24 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 45 yr., 6 mo., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles H. Bingel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
69			hrs. min.

8. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:

FATHER
12. Name: Henry Bingel
13. Birthplace:

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Feb. 1, 1946 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. Feb. 1 1946 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 19 46 at 1:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43, to Jan. 31 19 46 and that I last saw him alive on January 31 19 46

Immediate cause of death	DURATION
Acute suppurative nephritis	2 wks.
Due to Acute cystitis	1 mo.
Chronic myocarditis and myocardial degeneration	prior to 1946
Other conditions Dementia precox, hebephrenic type, prior to	1900

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robt Bertrand May M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 1-31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

CERTIFICATE OF DEATH

00584

Reg. Dist. No. 8J

1. PLACE OF DEATH:

County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Louise Blackstone

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 5 - 1945

8. AGE: Years	Months	Days	If less than one day
	4	19	..... hrs. ..... min.

9. Birthplace Carroll County, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Clifton S. Blackstone

13. Birthplace Maryland

MOTHER

14. Maiden name Ethel M. Fritz

15. Birthplace Maryland

16. Informant Clifton S. Blackstone

Address New Windsor Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 26-1946 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Uniontown, Md.

18. Funeral director H. H. Hartsfer & Sons

Address Union Bridge & New Windsor Md

19. Jan 31 1946 (Date rec'd by registrar) Ervin Buckel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Status Lymphaticus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John T. Round, Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 1-24-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

CERTIFICATE OF DEATH

00385 77

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION) C

2.(a) If veteran, name war: C

3. (a) FULL NAME Harry L. Bosley

3. (b) Social Security Number C

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single C

6.(b) Name of husband or wife: C

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 19, 1872

8. AGE: Years 73 | Months 6 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

FATHER 12. Name: Thomas M. Bosley

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Austria M. Williams

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs. John Braddock

Address: Greenmount, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-12-46 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Greenmount, Md

18. Funeral director: Jacob Winkelsas

Address: Manchester, Md

19. Jan. 10 19 46 (Date rec'd by registrar) John E. Heefner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Probably Jan. 9 19 46, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary occlusion	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Marsh, Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed 1/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00386

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs 7 da

Hospital, Institution, or street address (where death occurred): Spring Field State Hospital

How long in hospital or institution? 17 yrs 7 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. 506 Orkney Rd. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Joseph Brennes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 22nd 1868

8. AGE: Years	Months	Days	If less than one day
77	10	30	XX hrs. min.

9. Birthplace: Ind. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Phillip Brennes

13. Birthplace: Germany

MOTHER — 14. Maiden name: Catherine Boosmith

15. Birthplace: Ind.

16. Informant: Charles Brennes

Address: 506 Orkney Rd. Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 23 1946 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Road, Balto Md.

18. Funeral director: George J. Ruth Inc.

Address: 1735 Hartford Ave

19. 1-22 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 21st 1946 at 2-50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1929 to Jan 21 1946 and that I last saw h alive on Jan 21st 1946

Immediate cause of death	DURATION
Lobar Pneumonia	4 da
Due to	
Due to Chronic Myocarditis	16 yrs
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. J. Masten M.D. M. D. or other

Address: Sykesville Md. Date signed: 1-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15

00387

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: East Middle Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: DAVID CLAGGETT

3.(b) Social Security Number: 220-07-4146

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 20, 1903

8. AGE:	Years	Months	Days	If less than one day
	42	0	24	hrs. min.

9. Birthplace: Shady Grove, Md.
(Town, county, and state)

10. Usual occupation: --

11. Industry or business

MOTHER
12. Name: Sylvester Claggett
13. Birthplace: Rockville, Md.

FATHER
14. Maiden name: Emma Hawkins
15. Birthplace: Mount Zion, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal? Which?) Date thereof Jan 18 1946 (month) (day) (year)
Cemetery or crematory: Linson Park
Location: Linson Park near Rockville

16. Funeral director: Robert L. Snowden
Address: Rockville Md

19. Jan. 14, 1946 (Date rec'd by registrar) Albert R. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14, 1946 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20, 1945 to Jan. 14, 1946 and that I last saw him alive on Jan. 14, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 1-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on FILM No. I 00 JAN 28 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00388

★ Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Over 3 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or Institution? Over 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Virginia Lee Clark

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 12-1921

8. AGE: Years: 24 | Months: 3 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland
(Town, county, and state)

10. Usual occupation: dependent

11. Industry or business:

FATHER
12. Name: Edward Clark
13. Birthplace: Cumberland Md

MOTHER
14. Maiden name: Frances E. Giles
15. Birthplace: Cumberland

16. Informant: Edward Clark
Address: 136 W. 3rd St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 21, 1946 (month) (day) (year)
Cemetery or crematory: Cumberland
Location: Allegany Co. Md.

18. Funeral director: Curtis Stein, Inc.
Address: Cumberland, Md.

19. Jan. 18 1946 (Date rec'd by registrar) C. Henry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 17th 1946 at 645a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13th 1945 to Jan 17 1946 and that I last saw h.. alive on Jan 16th 1946

Immediate cause of death	DURATION
Chr. Myocarditis	17 yrs
Due to	
Mitral Stenosis	?
Due to	
Congenital Luetic	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. F. Haston M.D.
M. D. or other
Address: Sykesville Md. Date signed 1/17/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-c)

CERTIFICATE OF DEATH

06389

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 wks
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Rachael Irene Compton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Francis M. Compton
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): January 11 1912

8. AGE:

Years	Months	Days	If less than one day
27	0	7	...hrs. ...min.

9. Birthplace: Hampstead Md (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: Home
12. Name of father: Lesley E. Stepp
13. Birthplace of father: Hampstead Md
14. Maiden name of mother: Sarah Alice Reed
15. Birthplace of mother: Manchester Md
16. Informant: Mrs Lesley Stepp
Address: Manchester Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof 1-22-46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Carol Whitelo Sapp
Address: Manchester Md.
19. Jan. 21 1946 Mrs. W.J.S. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 1946, at 8 45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1945 to Jan 18 1946
and that I last saw h[illegible] alive on January 18 1946

Immediate cause of death	DURATION
Subacute Bacterial Endocarditis	?
Due to: Staphylococcus Viridans	?
Due to: Pulpalcemia	
Other conditions: Rheumatic Cardio Vascular Disease	?

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: Joseph E. Bush MD
M. D. or other
Address: Hampstead Md Date signed 1-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

00390

1. PLACE OF DEATH

County Carroll Registration Dist. No. 74

Village or City Sykesville R 1 No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residanca in city or town whara death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME James Thomas Conaway

(a) Residence: No. Sykesville, Md R 1 St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ellen Triplett

6. DATE OF BIRTH (month, day, and year) July 1, 1862

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	6	19	

OCCUPATION

8. Trede, profassion, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, atc. Farmer

9. Industry or business in which work was dona, as SILK MILL, SAW MILL, BANK, etc.

10. Oate deceased last worked at this occupation (month and year) 1945

11. Total time (yaars) spent in this occupation 60

12. BIRTHPLACE (city or town) (State or country) Carroll County, Md

FATHER

13. NAME Thomas B. Conaway

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Dorothy Stokesdale

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Vernon C. Conaway (Address) Sykesville, Md.

18. BURIAL, CREMATION, OR REMOVAL Place Gambrel, Md., Oata Jan. 23, 1946

19. UNDERTAKER J. Francis Reese (Addrass) Westminster, Md.

20. FILED Jan. 22, 1946 C. Harry Estes Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January (Month) 20 (Day), 1946 (Yaar)

22. I HEREBY CERTIFY, That I attended deceasad from 1935, 19, to Jan 20, 19 46

I last saw him alive on Jan 20, 19 46; death is said to have occurrad on the data statad above, at 9:00 P m.

The PRINCIPAL CAUSE OF DEATH and related causes of importanca ware as follows:

	Date of onset
Senility	
chronic myocarditis	
due: arteriosclerosis with hypertension	
chronic intestinal nephritis	

Othar Contributory Causes of importance:

Name of operation Oate of

What tast confirmad diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accidant, suicide, or homicide? Date of injury, 19

Whare did injury occur? (Specify city or town, county and State)

Spacify whethar injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disaase or injury in any way related to occupation of deceasad? No

If so, spacify

(Signad) D. M. Layton M. D.

(Addrass) Sykesville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00391

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 2 mos 28 da

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? 1 yr 2 mos 28 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Montg. Co.

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Stella Queen Craun

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: William Craun

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 19th 1886

8. AGE: Years 59 | Months 7 | Days 19 | If less than one day ____ hrs. ____ min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER — 12. Name: David Breneman

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Mary Snyders

MOTHER — 15. Birthplace: Virginia

16. Informant: William Craun

Address: 523 Bonifant St. Silver Spring

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-7-46 (month) (day) (year)

Cemetery or crematory

Location: Washington D. C.

18. Funeral director: W. W. Chambers Co

Address: 1400 Chapin St. N.W. Wash. D.C.

19. Jan. 8 1946 (Date rec'd by registrar) C. A. Geary (Deputy) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7th 1946, at 5-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18th 1944, to Jan 7th 1946, and that I last saw h[illegible] alive on Jan 7th 1946.

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 da
Due to:	
Due to: Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Gaston M.D. (M. D. or other)

Address: Sykesville Md. Date signed 1/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

CERTIFICATE OF DEATH

00392

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma J. Curley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 28, 1883

8. AGE:

Years	Months	Days	If less than one day
62	6	3	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Frederick Wilson

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Clara Curley

MOTHER — 15. Birthplace: Md.

16. Informant: Mrs. Nannie L. Ely

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3 1946 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Balto. Md.

18. Funeral director: C. Harry Wees

Address: Sykesville, Md.

19. Jan. 2 1946 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1st 1946, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jul 1945, to Jan 1 1946

and that I last saw h[illegible]w alive on Dec 31 1945.

Immediate cause of death	DURATION
(a) Carcinoma of Lung	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: H A Burns M D
M. D. or other

Address: Sykesville Md. Date signed 1/2/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00393

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 4mos., 4 days.
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or Institution? 1 yr., 4 mos., 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Marshall D. DeConway

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: ----
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 1, 1893

8. AGE: Years	Months	Days	If less than one day
52	6mos	18	____ hrs. ____ min.

9. Birthplace: Illinois (Town, county, and state)
10. Usual occupation: Pharmacist
11. Industry or business: Pharmacy

FATHER
12. Name: Elzear DeConway
13. Birthplace: England

MOTHER
14. Maiden name: Ida Featherstone
15. Birthplace: New York

16. Informant: Hospital records
Address: [illegible]

17. Burial, cremation, or removal (which?) Burial Date thereof Jan 22/46 (month) (day) (year)
Cemetery or crematory: St Mary's
Location: annapolis md
18. Funeral director: D L Hopkins
Address: annapolis md

19. Jan 22 1946 (Date rec'd by registrar) A. Harry Weems Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1946, at 8:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1944, to Jan 19 1946 and that I last saw him alive on Jan 19 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs
Due to:	
Due to:	
Other conditions: Schizophrenia, Catatonic type	21 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other
Address: Springfield State Hosp. Sykesville Md Date signed 1-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

00394

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 72

1. PLACE OF DEATH:
County Carroll
City or town Union Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Williams Dell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Mabel Close Dell
6.(c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Oct. 7 - 1915

8. AGE:	Years	Months	Days	If less than one day
	30	2	28	...hrs. ...min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Edgar Dell
13. Birthplace Md.
MOTHER 14. Maiden name Cora Baxton
15. Birthplace Md.
16. Informant Mabel Close Dell
Address Washington Rd. Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 5 1946 (month) (day) (year)
Cemetery or crematory Bridge Lutheran Cem.
Location Westminster, Md.
18. Funeral director H. Bankard & Son
Address Westminster, Md.
19. Jan. 7th 1946 (Date rec'd by registrar) Calvin T. Bankard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1946, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945, to Jan 5 1946
and that I last saw him alive on Jan 4 1946

Immediate cause of death	DURATION
Carcinoma Bowels	
Pleural Effusion	
Due to Uremia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M. D. or other
Address Westminster Md. Date signed 1-6-46

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

00395

Reg. Diat. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Olive
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D? Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: BASIL DORSEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

B.(b) Name ~~of husband~~ or wife: Letticia Dorsey
deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1881

8. AGE:

Years	Months	Days	If less than one day
64	8	23	hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Roderick Dorsey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jemima
15. Birthplace: Maryland

16. Informant: Mrs. Alice M. Dorsey
Address: R.D. Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 1-5-46 (month) (day) (year)
Cemetery ~~or crematory~~: Fairview
Location: Covers Corner, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Jan 4 1946 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 3, 1946 at 12:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 28 1945 to Jan 3 1946
and thet I last saw him alive on January 2 1946

Immediate cause of death	DURATION
Cardiac Decompensation	6 wks
Due to: Chr. Myocarditis	? yrs
Due to:	
Other conditions: Uremia	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J Stanley Grabill M. D. or other
Address: Mt Airy, Md Date signed 1/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlen St., Baltimore

CERTIFICATE OF DEATH

06396

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1213 Upton St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARIE WARREN DORSEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30, 1911

8. AGE:	Years	Months	Days	If less than one day
	34	5	1	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Charles Hammond
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Fannie Dorsey
15. Birthplace: Baltimore, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-7-46 (month) (day) (year)
Cemetery or crematory: St Peters Cemetery
Location: Baltimore Md

18. Funeral director: Mrs Katie R Williams
Address: 322 N Schroeder Street

19. Jan. 1, 1946 (Date rec'd by registrar) Albert R. Stansbury Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1, 1946, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 3, 1945 to Jan. 1, 1946 and that I last saw her alive on Jan. 1, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1937
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 1-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00397

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:
County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Walter Engel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Irene Albaugh
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 31 1866

8. AGE: Years 79 | Months 4 | Days 3 | If less than one day ..... hrs. ..... min.

9. Birthplace: Carroll County, Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: David Engel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Matilda Fiskus
15. Birthplace: Maryland

16. Informant: Morton A. Engel
Address: New Windsor, Md.

17. Burial
(Burial, cremation, or removal: Which?)
Date thereof: Jan. 6 1946
(month) (day) (year)

Cemetery or crematory: Pipe Creek Cem.
Location: Uniontown Road

18. Funeral director: H. H. Hartsler & Sons
Address: Union Bridge & New Windsor Md.

19. Jan 7 1946 Ernest Myers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 1946 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1945 to January 3 1946
and that I last saw him alive on January 2 1946

Immediate cause of death	DURATION
Hemiplegia	2 days
Due to: Arteriosclerotic C-V disease	—
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: James T. Marsh M.D.
M. D. or other
Address: Westminster Md. Date signed: Jan 3-1945

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00398

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 8 mos., 22 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2329 Madison Ave., Apt. 4B
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: CLIFTON FIELDS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 18, 1890

8. AGE:	Years	Months	Days	If less than one day
	55	8	23	hrs. min.

9. Birthplace: Charlestown, West Virginia (Town, county, and state)
10. Usual occupation: Manager of Club
11. Industry or business

FATHER
12. Name: John Fields
13. Birthplace: Chambersburg, Pa.

MOTHER
14. Maiden name: Evelyn Herbert
15. Birthplace: Winchester, Va.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15, 1946 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetary
Location: Baltimore, Md.
18. Funeral director: Mrs. Geo. H. Holland.
Address: 1631 David Hill ave.
19. Jan. 11, 1946 (Date rec'd by registrar) Albert R. Brantley Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11, 1946 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19, 1943, to Jan. 11, 1946 and that I last saw him alive on January 11, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 1943
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 1-11-46

M

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VS A15 T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 00392

1. PLACE OF DEATH:

County Carroll

City or town Myers District, Westminster (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster, R. D. 1 (If outside city or town limits, write RURAL and give nearest town)

Street No. Myers District (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Herbert Henry Brock

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elizabeth (Crouse) Brock

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Dec. 20 1875

8. AGE:

Years	Months	Days	If less than one day
70	1	0	...hrs. ...min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Farming

11. Industry or business Farm

FATHER 12. Name John H. Brock

FATHER 13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Cornelia Matlock

MOTHER 15. Birthplace Carroll Co. Md.

16. Informant Hilda E. Brock

Address Westminster, Md R. D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23 1946 (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Silver Run, Md.

18. Funeral director T. W. Little & Son

Address Littlestown, Pa. R.F.D. 4

19. Jan. 21st. 1946 (Date rec'd by registrar) Calvert E. Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1946, at 10:20 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1945, to Jan. 20 1946 and that I last saw h... alive on Jan. 20 1946

Immediate cause of death	DURATION
Myocardial degeneration & Valvular Insufficiency & Edema	
Due to Arteriosclerosis (General) & Hypertension	
Due to Prostatic Hypertrophy	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Date signed 1/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

(0040)

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs. 1 mo. 4 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 16 yrs. 1 mo. 4 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1301 Charles Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SARAH GLOVER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 2, 1869

8. AGE: Years	Months	Days	If less than one day
76	10	30	hrs. min.

9. Birthplace: (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Richard E. Glover
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susan Conner
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Sykesville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12, 1946 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.

18. Funeral director: C. Henry Rees
Address: Sykesville, Md.

19. Jan. 12 1946 (Date rec'd by registrar) C. Henry Rees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8th 1946, at 7.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4 1929 to Jan. 8 1946
and that I last saw h.. alive on Jan. 8 1946

Immediate cause of death	DURATION
General Arteriosclerosis	16 yrs
Due to:	
Due to:	
Other conditions: Paranoid condition	over 16 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maud M. Rees M. D.
M. D. or other
Address: Sykesville Md. Date signed: 1-8-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

06481

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yr., 6 mo., 12 Days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 yr., 6 mo., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1021 E. Biddle Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Grace Gortt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Henry Gortt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 15, 1883

8. AGE: Years	Months	Days	If less than one day
62	1	07	hrs. min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: John Lyford

13. Birthplace: York

MOTHER — 14. Maiden name: ——— Pettigore

15. Birthplace: York

16. Informant: Springfield State Hospital records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 25, 1946 (month) (day) (year)

Cemetery or crematory: Maryland Memorial Park

Location: Balto. Md.

18. Funeral director: William Cook, Inc.

Address: 1217 St. Paul St.

19. Jan. 23 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 1946 at 7 25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to Jan. 22 1946 and that I last saw h[illegible] alive on Jan. 22 1946

Immediate cause of death	DURATION
Arteriosclerosis	4 yrs
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May M.D.
M. D. or other

Address: Sykesville, Md. Date signed 1-22-46

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00402

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 9 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1204 McElderry Ct.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HILDA HARPER

3.(b) Social Security Number: 220-14-1631

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Elijah Harper
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): April 28, 1920

8. AGE:	Years	Months	Days	If less than one day
	25	8	13	....hrs. ....min.

9. Birthplace: Bellhaven, N.C. (Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business

FATHER
12. Name: Henry Windley
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Emma Spencer
15. Birthplace: Howard County, N.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 16, 1946 (month) (day) (year)
Cemetery or crematory: Sidney, N. Carolina
Location:
18. Funeral director: A A Gaddis
Address: 2101 McCulloh St

19. Jan. 11, 1946 (Date rec'd by registrar) Albert R. Goodhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 11, 1946 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2, 1945 to Jan. 11, 1946 and that I last saw her alive on Jan. 11, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 1-11-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00403

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 3 mos 12 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 3 mos 12 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State: Md County: Wash

City or town: Sharpsburg (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma Florence Fines

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

8.(b) Name of husband or wife: William Hershberger

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 10 - 1871

8. AGE: Years: 74 | Months: 2 | Days: 28 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business

FATHER — 12. Name: unknown

FATHER — 13. Birthplace

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace

16. Informant: Mrs Ann Stretzer

Address: Sharpsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 15 1946 (month) (day) (year)

Cemetery or crematory: Sharpsburg Md

Location: Sharpsburg Md

18. Funeral director: Edith V Hoat

Address: Williamsport md

19. Jan. 13 1946 (Date rec'd by registrar) C. Harry Weu Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12 1946, at 8-38 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 38 1943, to Jan 12 1946 and that I last saw h[illegible] alive on Jan 12 1946

Immediate cause of death	DURATION
Bronchopneumonia	1 wk
Due to: Influenza	2 wks
Due to: Arteriosclerosis	.....
Other conditions: Hypertension	9

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or other

Address: Sykesville Date signed 1/12/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 06404 / 26

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Anna Christina Hoffman

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widow

6.(b) Name of husband or wife Coon Hoffman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 12 - 1862

8. AGE: Years	Months	Days	If less than one day
83	2	1	..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden name Not Known
15. Birthplace

16. Informant Mrs Russell Haines
Address Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 15 1946 (month) (day) (year)
Cemetery or crematory Lister Cemetery
Location Westminster, Md.
18. Funeral director H Bankard Sons
Address Westminster, Md.
19. 1/14 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13-46 19..... at 4(?) P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-12- 19 46, to 1-13 19 46 and that I last saw h.. alive on 1-13-46 19.....

Immediate cause of death	DURATION
Carcinoma of breast	1 yr (?)
Due to	
Due to	
Other conditions Mal nutrition	3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE N. C Sloan M. D. or other
Address Westminster Date signed 1-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00405

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-C

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 E Centre
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mollie Hughes

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Charles W. Hughes
6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Aug. 28 - 1871

8. AGE: Years 74 | Months 5 | Days 6 | If less than one day ....hrs. ....min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Christopher Schettle
13. Birthplace Md.

MOTHER
14. Maiden name Not known
15. Birthplace " "

16. Informant Mrs. Albert Stone
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 16 - 1946 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18. Funeral director H. Bankard & Son
Address Westminster, Md.

19. 1/14 - 46 (Date rec'd by registrar) 19.... C. L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 (1946) at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1945 to Jan 14 1946
and that I last saw her alive on Jan 12, 1946

Immediate cause of death	DURATION
Cancer of uterus with extensive metastasis	5+ yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. Reese Wilson M. D. or other
Address Westminster Md. Date signed 1/14/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-t)

CERTIFICATE OF DEATH

00406 ★ Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 107 West York Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM HUNTER

3.(b) Social Security Number: 243-03-3663

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Sarah Hunter
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): May 16, 1906

8. AGE: Years	Months	Days	If less than one day
39	8	12	...hrs. ...min.

9. Birthplace: Greenville, N.C. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Thomas Hunter
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Chelsa Harris
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1946 (month) (day) (year)
Cemetery or crematory: Greenville N.C.
Location:
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroder St.

19. Jan. 28, 1946 (Date rec'd by registrar) Albert R. [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28, 1946 at 1:30A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 14, 1946, to Jan. 28, 1946 and that I last saw him alive on January 28, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Oct. 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other
Address: Henryton, Md. Date signed: 1-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00467 74

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5501 Edmondson Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elise Hutton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5 17 1857

8. AGE: Years	Months	Days	If less than one day
88	8	3	..... hrs. ..... min.

9. Birthplace Montgomery County Md.

(Town, county, and state)

10. Usual occupation farming

11. Industry or business

FATHER 12. Name Orlando Hutton

13. Birthplace Md.

MOTHER 14. Maiden name Sidney Buchanan

15. Birthplace Md.

16. Informant Cathrine Adams

Address Sandy Springs Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan 20 1946 (month) (day) (year)

Cemetery or crematory Bethesda Md

Location

18. Funeral director W. R. Humphreys

Address Bethesda Md

19. Jan. 20 1946 (Date rec'd by registrar) C. Harry Eckel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1946, at 12.40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 8, 1946, to Jan. 20 1946

and that I last saw h... alive on Jan. 20 1946

Immediate cause of death	DURATION
chronic myocarditis	
withmyodegeneration	years
Due to arteriosclerosis	
Due to	
Other conditions psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ida Ramm M. D. or other

Address Springfield State Hosp. Date signed 1-20-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06408

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 10 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 217 Beale Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LUTHER JENKINS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 11, 1931

8. AGE:	Years	Months	Days	If less than one day
	14	3	27	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business

FATHER
12. Name: Alonzo Jenkins
13. Birthplace: Greenville, N.C.

MOTHER
14. Maiden name: Elizabeth Alford
15. Birthplace: Bennettsville, S.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-13-46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location:
18. Funeral director: Mrs. Robt. Elliott
Address: 1129 E. Caroline St. Balto.

19. Jan. 8, 1946 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8, 1946 at 3:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28, 1945 to Jan. 8, 1946 and that I last saw him alive on Jan. 8, 1946

	DURATION
Immediate cause of death: Tuberculous Meningitis	Dec. 25 1945
Due to: Pulmonary Tuberculosis	Jan. 1939
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 1-8-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00469

Reg. Diat. No. 72

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Union Mills

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Union Mills

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Norman Thomas Keeney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 20 - 1945

8. AGE: Years | Months 5 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace Hanover - Pa (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Norman E. Keeney

FATHER 13. Birthplace Woodsville Md

MOTHER 14. Maiden name Flossie Maryanna Warner

MOTHER 15. Birthplace Manchester

16. Informant Norman E. Keeney

Address Westminster - Md. Route 7

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30 - 1946 (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Taylorsville Maryland

18. Funeral director H D Hershey Sons

Address Union Bridge & New Windsor Md

19. Jan 29th 1946 Calvin C Bankert

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29 1946 at 5:00 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ____ 19__, to ____ 19__

and that I last saw h... alive on ____ 19__

Immediate cause of death	CURATION
Pneumonia -	2 days
No autopsy was done. Kind of pneumonia, Streptococcus.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James A Woods Deputy Medical Examiner

M. D. or other

Address Westminster Md Date signed 1/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

06410

Reg. Diat. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 18 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 2 months 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Clarksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Merle Vivian King

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lucy King

6.(c) If alive, give age 18 years

7. Birth date of deceased (mo., day, yr.) February 16, 1925

8. AGE:

Years	Months	Days	If less than one day
20	10	27	hrs. min.

8. Birthplace Clarksburg, Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Walden V. King

13. Birthplace Clarksburg, Md

MOTHER

14. Maiden name Lena Shipley

15. Birthplace Maryland

18. Informant Lucy King (wife)

Address Clarksburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 14 1946 (month) (day) (year)

Cemetery or crematory Clarksburg Md

Location Montgomery Co Md

18. Funeral director Roy W Barber

Address Sykesville Md

19. Jan 12 1946 (Date rec'd by registrar) C. Edgar Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1946, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 1945, to January 13 1946

and that I last saw him alive on January 11 1946

Immediate cause of death	DURATION
Chronic myocarditis	?
Due to Rheumatic heart disease	?
Edema of brain	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE M. Virginia Beyer M.D. (M. D. or other)

Address Sykesville, Md Date signed Jan-12-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06411

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
Street No. 415 N. Franklin Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nellie Czischeck Knodle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Clifton Knodle
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9/20/1873

8. AGE: Years	Months	Days	If less than one day
72	4	8	..... hrs. ..... min.

9. Birthplace Cincinnatti, Ohio (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Oscar Czischeck
13. Birthplace Germany

MOTHER
14. Maiden name Elizabeth Brune
15. Birthplace Germany

16. Informant Clifton Knodle
Address 415 N. Franklin St. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30 1946 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Hagerstown, Md.
18. Funeral director C. M. Lutz & Son
Address Hagerstown, Md.

19. Jan. 28 1946 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1946 at 2:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/25/ 1946 to 1/28/ 1946 and that I last saw her alive on Jan. 28 1946

Immediate cause of death	DURATION
Chronic Myocarditis	unknown
Due to Decompensated Arteriosclerosis	
Due to	
Other conditions Psychosis due to Circulatory Changes (Include pregnancy within 3 months of death)	unknown

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Arnold H. Eichert M.D. (M. D. or other)
Address U.S. Hosp. Sykesville, Md. Date signed 1-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (836)

CERTIFICATE OF DEATH

06412 P.

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 2 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 5 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1732 Fleet Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Czeslaw S. Korzeniewski

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Stefania

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
60 (?)			hrs. min.

9. Birthplace: Poland (Suwalki)
(Town, county, and state)

10. Usual occupation: Watchmaker

11. Industry or business:

FATHER
12. Name: Stanislaus Korzeniewski
13. Birthplace: Poland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Poland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/7/46 (month) (day) (year)

Cemetery or crematory: Holy Rosary

Location: German Hill Road

18. Funeral director: M. F. Sadowski & Son

Address: 1808 Eastern Avenue

19. 1-5 (Date rec'd by registrar) 19 46 A W Wedneck adk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4 1946, at 11:10a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21 1945, to Jan. 4 1946 and that I last saw him alive on January 4 1946

Immediate cause of death	DURATION
Cerebral thrombosis	24 hrs.
Due to: Arteriosclerosis, prior to	1944
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	1 year

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 1-4-46

VS (A15) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

00413

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yr., 2 mo., 18 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 8 yr., 2 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frederick Kothe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 12, 1851

8. AGE: Years	Months	Days	If less than one day
94	6	24	hrs. min.

9. Birthplace: Baltimore City, Maryland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: agriculture

FATHER 12. Name: George Kothe

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Catherine Bentz

MOTHER 15. Birthplace: Germany

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 8 1946 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto. Md.

18. Funeral director: Williams Cook, Inc.

Address: 1217 St. Paul St.

19. Jan. 6 1946 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1946, at 11:50a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to Jan. 6 1946 and that I last saw him alive on January 6 1946

	DURATION
Immediate cause of death: Senility	28 yrs.
Due to: Arteriosclerosis	28 yrs.
Due to:	
Other conditions: Senile psychosis, simple deterioration	28 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.

Robert Bertrand May, M.D. M. D. or other

Address: Springfield State Hospital, Sykesville, Maryland Date signed: 1-6-46

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06414

★ Reg. Dist. No. 94

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs 2 mo 15 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 yrs 2 mo 15 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wash Co

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Laura Catherine Kurtz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 27 - 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	9	15		

9. Birthplace: Penna
(Town, county, and state)

10. Usual occupation: Home work

11. Industry or business:

FATHER — 12. Name: Frank Kurtz

FATHER — 13. Birthplace: Pa

MOTHER — 14. Maiden name: Leona Calomer

MOTHER — 15. Birthplace: Pa

18. Informant: Mrs Myrtle Kurtz

Address: Waynesboro Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/46 (month) (day) (year)

Cemetery or crematory: Numery

Location: Numery

18. Funeral director: Walter J Gourd

Address: 27 South Church St Waynesboro Pa.

19. Jan. 14 1946 (Date rec'd by registrar) C. Henry Gilbert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12th 1946, at 5-20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 27 1945, to Jan 12 1946 and that I last saw h.. alive on Jan 12th 1946

Immediate cause of death	DURATION
Coronary Thrombus	5 minutes
Due to: Arteriosclerosis	9
Due to: Hypertension	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of Injury: Injured at work?

23. SIGNATURE: W. W. Master M.D. M. D. or other

Address: Sykesville Md Date signed: 1/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-b)

00415

CERTIFICATE OF DEATH

Reg. Dist. No. 72

1. PLACE OF DEATH:

County Carroll

City or town Westminster R.D.1 Silver Run

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster R.D.1 Silver Run

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Emma Kate Lawyer

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Ira G. Lawyer Dead

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9. 1862

8. AGE:

Years	Months	Days	If less than one day
83	2	5	hrs. min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

FATHER

12. Name Levi Singling

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Catherine Twibling

15. Birthplace Carroll Co. Md.

16. Informant Emma K. Lawyer

Address Westminster. Md. R.D.1

17. Burial Date thereof Jan. 17 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Silver Run. Md.

18. Funeral director J. M. Little & Son

Address Littlestown, Pa. Rel. R.D.2.

19. June 15th 1946 Calvin T. Bankert

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1946 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1945 to Jan 14 1946

and that I last saw her alive on Jan. 9 1946

Immediate cause of death	DURATION
Cancer of uterus	4 yrs.
Due to Secondaries.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Reese Wilbern M. D. or other

Address Westminster Date signed 1-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Change of age; Doctor's statement filmed 3-19-46 G101.-L

STATE OF MARYLAND—CERTIFICATE OF DEATH 00416

1. PLACE OF DEATH 13(a)

County Carroll Registration Dist. No. 74

Village or City Greenville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

Social Security No. - 217-07-0587

2. FULL NAME James W. Lyon Jr.

(a) Residence: No. Greenville - Sykesville St. P.O. Ward. Md.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Zella Patterson

6. DATE OF BIRTH (month, day, and year) Feb. 14, 1883

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	11	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Grain Broker

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Md.
(State or country)

FATHER

13. NAME James W. Lyon

14. BIRTHPLACE (city or town) York.
(State or country)

MOTHER

15. MAIDEN NAME Frances M. Nelson

16. BIRTHPLACE (city or town) Va.
(State or country)

17. INFORMANT Mrs. Zella P. Lyon
(Address) Sykesville, Md.

18. BURIAL, CREMATION, OR ~~REMOVAL~~
Place St. Thomas Cem. Date Jan. 23, 1946

19. UNDERTAKER Williams Cook, Inc.
(Address) 1217 E. Fayette St.

20. FILED Jan. 22, 1946 C. Harry Ewell
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January (Month) 21 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1944, 19..., to Jan 21, 1946

I last saw him alive on Jan. 21, 1946; death is said to have occurred on the date stated above, at 9:00 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Chr. myocarditis	
Chr. arteriosclerosis	
with hypertension	
Chr. interstitial nephritis	

Other Contributory Causes of importance:

Name of operation — Date of

What test confirmed diagnosis? — Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury, 19...

Where did injury occur? (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) W. H. Lawrence M. D.

(Address) Reisterstown, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

06417

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 7 mo. 28 da.
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 yr. 7 mo. 28 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 3 North Collington Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME EDITH MILNOVSKY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Joseph Milnovsky
6.(c) If alive, give age unknown years
7. Birth date of deceased (mo., day, yr.) October (unknown) 1894

8. AGE: Years	Months	Days	If less than one day
51	3		hrs. min.

9. Birthplace Poland (Town, county, and state)
10. Usual occupation housewife
11. Industry or business home
FATHER 12. Name Elias Liberatsky
13. Birthplace Poland
MOTHER 14. Maiden name Ruth Felsman
15. Birthplace Poland
18. Informant Hospital Records
Address Sykesville, Maryland.
17. Burial (Burial, cremation or removal. Which?) Date thereof 1-14-46 (month) (day) (year)
Cemetery or crematory Mt Carmel
Location Germany Hill Rd.
18. Funeral director Jack Lewis Lee
Address 1439 E. Baltimore St
19. Jan. 13 1946 (Date rec'd by registrar) C. Harry Weber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1946 at 2.30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4, 1944 to Jan. 13 1946
and that I last saw h[illegible] alive on January 13, 1946

Immediate cause of death	DURATION
Coronary Thrombosis	12 hrs.
Due to	
Due to	
Other conditions Schizophrenia--catatonic type	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D.
M. D. or other
Address Sykesville Md Date signed 1-13-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06418

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 8 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 months 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Caroline G. Morris

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas Morris

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 14, 1861

8. AGE: Years	Months	Days	If less than one day
84	10	7	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Edward Kosack
13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-21-46 (month) (day) (year)

Cemetery or crematory:

Location: Bethesda, Md.

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda, Maryland.

19. Jan. 21 1946 (Date rec'd by registrar) C. Perry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21 1946, at 8:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/13/ 1945, to 1/21/ 1946 and that I last saw her alive on January 21 1946

Immediate cause of death	DURATION
Bronchopneumonia, terminal	2 days
Due to	
Due to	
Other conditions: Senile Psychosis, simple deterioration	6 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M.D. or other

Address: Springfield State Hospital, Sykesville, Maryland Date signed 1/21/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

00419

Reg. Dist. No. 88

1. PLACE OF DEATH:
County: Carroll
City or town: New Windsor, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Flora Alice Myers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 15 - 1863

8. AGE:

Years	Months	Days	If less than one day
82	11	24	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Practical nurse
11. Industry or business
12. FATHER — Name: Jesse Myers
13. FATHER — Birthplace: Maryland
14. MOTHER — Maiden name: Mary Catherine Myers
15. MOTHER — Birthplace: Maryland
16. Informant: Edna Wilson
Address: New Windsor, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 10 - 1946 (month) (day) (year)
Cemetery or crematory: Winter's Cemetery
Location: New Windsor, R D 1
18. Funeral director: D D Hartzler & Sons
Address: Union Bridge & New Windsor, Md
19. Jany 10 1946 (Date rec'd by registrar) Ernest G Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8 1946, at 7:25 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to January 8 1946
and that I last saw h... alive on January 7 1945
Immediate cause of death: Generalized Arteriosclerosis

	DURATION
	Years
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James T Round M.D.
M. D. or other
Address: Westminster Md Date signed: Jan 8 - 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

00420

Reg. Dist. No. 72

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster, R.D.2 Union Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster, R.D.2, Union Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Herbert Jerriah Myers

3.(b) Social Security Number 213-18-8468

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah (Fauver) Myers

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 20 1876

8. AGE:

Years	Months	Days	If less than one day
69	5	22	hrs. min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Saw Mill Operator

11. Industry or business: Saw Mill

FATHER

12. Name: Jerriah Myers

13. Birthplace: Carroll County Md

MOTHER

14. Maiden name: Alberta Bankert

15. Birthplace: Carroll County, Md.

16. Informant: Mrs. Herbert J. Myers

Address: Westminster, Md R.D. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15 1946 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Union Mills, Md.

19. Funeral director: J. W. Little & Son

Address: Littlestown, Pa. R.F.D.

18. Jan 12 1946 (Date rec'd by registrar) Calvin Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1946, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1st 1945, to Jan 12 1946

and that I last saw h[illegible] alive on Jan 12 1946

Immediate cause of death	DURATION
Cancer of Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John J. Stewart M. D. or other

Address: Westminster Md. Date signed Jan 12-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00421

Reg. Dist. No. 94

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No.: 257 N. Exeter Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph PATRO

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6.(b) Name of husband or wife: Frances Pacluba -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years	Months	Days	If less than one day
55			hrs. min.

9. Birthplace: Warsaw - Poland (Town, county, and state)

10. Usual occupation: Baker

11. Industry or business: Kahlman & Lansman (Bakers)

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown.

16. Informant: Michael M. Patro

Address: 2101 E. Federal Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/46 (month) (day) (year)

Cemetery or crematory: St. Stanislaus

Location: Fundale ave.

18. Funeral director: John F. Connelly.

Address: 419 Eastern Ave. Essex 21

19. 1-14 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1946 at 7:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1946, to January 10 1946 and that I last saw h[illegible] alive on January 10 1946

Immediate cause of death	DURATION
Pulmonary tuberculosis	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Address: S. S. Hosp. Sykesville Md. Date signed: 1-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

00422 Reg. Dist. No. 78

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Olive
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Olive
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural--Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Curtis Sigler Penn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emily Ruth Penn

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): April 1, 1878

8. AGE: Years: 67 | Months: 9 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Milton H. Penn
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary K. Grimes
15. Birthplace: Maryland

16. Informant: Mrs. Emily R. Penn
Address: Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-21-46 (month) (day) (year)
Cemetery or crematory: Bethel Church of God
Location: nr. Winfield, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 1-20 (Date rec'd by registrar) 1946 E. M. Fauver Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 1946, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
(a) Coronary disease	
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: James T. Shard Deputy Medical Examiner M. D. or other
Address: Westminster Md. Date signed 1/18/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-9)

00423

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs. 6 mo. 29 da.
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 yrs. 6 mo. 29 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1442 Hull Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
JANE BLANCHE PERRY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William Perry
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): December 30, 1883

8. AGE: Years	Months	Days	If less than one day
62	0	16	hrs. min.

9. Birthplace: Canada
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home

FATHER
12. Name: George B. Kingston
13. Birthplace: Canada

MOTHER
14. Maiden name: Ellen Mc Clean
15. Birthplace: Canada

16. Informant: Hospital Records
Address: Sykesville, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 19, 1946 (month) (day) (year)
Cemetery or crematory: Holy Cross Cem.
Location: A. B. Co., Md.
16. Funeral director: Charles F. Dill
Address: E. Front Ave Balto. Md

19. Jan. 16 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15th. 1946, at 11.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27, 1944 19 to Jan. 15 1946
and that I last saw her alive on Jan. 15th 1946

Immediate cause of death	DURATION
carcinoma of the head of pancreas with metastases to the liver	over 1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Race M.D.
M. D. or other
Address Sykesville, Md. Date signed Jan. 15 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of birth date of deceased is shown on

FILM No. I 0 0 JAN 18 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18, Md.

CERTIFICATE OF DEATH

06424

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 W. Green
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clara Elizabeth Pittinger

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife William Pittinger
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) August 10 - 1867

8. AGE: Years	Months	Days	If less than one day
88	5	2	..... hrs. ..... min.

9. Birthplace Uniontown, Fred. Co. Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Martin Nicodemus
13. Birthplace Fred. Co. Md.
MOTHER 14. Maiden name Lucinda Carter
15. Birthplace Frederick, Md.
16. Informant J. R. Sheats
Address 103 W. Green St. Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15-1946 (month) (day) (year)
Cemetery or crematory Evergreen Cemetery
Location Uniontown, Fred. Co. Md.
18. Funeral director H. Bankard & Son
Address Westminster Md.
19. 1/14 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1946 at 3:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1945 to Jan 12 1946
and that I last saw her alive on Jan 12 1946

	DURATION
Immediate cause of death Arteriosclerosis (General) Myocardial degeneration & Valvular insufficiency	
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE W. G. Leppleher M. D. or other
Address Westminster Md. Date signed 1/12/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-a

CERTIFICATE OF DEATH

06425

★ Reg. Dist. No. 78

1. PLACE OF DEATH:
County: Carroll
City or town: Rural--Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural--Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MINNIE ELLSWORTH POOLE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband ~~or wife~~: Samuel C. Poole
deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 9, 1861

8. AGE: Years	Months	Days	If less than one day
84	0	22	hrs. min.

9. Birthplace: Howard Co. Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Milton L. Becraft
FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Rebecca Watkins
MOTHER 15. Birthplace: Maryland

16. Informant: Mrs. Francis Hunter
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof: 1-4-46 (month) (day) (year)
Cemetery ~~or crematory~~: Mt. Olive
Location: Mt. Olive, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 1-3-46 (Date rec'd by registrar) E. McFarren Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 1, 1946 at 4 P; M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 22 1945, to Jan 1 1946 and that I last saw h~~er~~ alive on Jan 1 1946

Immediate cause of death: Lobar Pneumonia — DURATION 4 days
Due to: La Grippe and General debelity due to age
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C M Waltz Poole M. D. or other
Address: Mt Airy Md Date signed 1-2-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-C)

CERTIFICATE OF DEATH

00426

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 6 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LULA POWELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 15, 1893

8. AGE: Years	Months	Days	If less than one day
53	0	10	hrs. min.

9. Birthplace: Anne Arundel County (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Frank Powell
13. Birthplace: Anne Arundel County

MOTHER
14. Maiden name: Rachel Junior
15. Birthplace: Anne Arundel County

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: 1/28/46 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Laurel, Md.
18. Funeral director: Katie L. Williams
Address: 322 N. Sharon St.

19. Jan. 25, 19 46 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25, 1946 at 8:15A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19, 1945 to Jan. 25, 1946 and that I last saw her alive on January 25, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 1-25-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00427

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 4 mos., 6 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: 1006 N. Bond Street
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FLORINE IDEL PRESTON

3.(b) Social Security Number: 220-18-6379

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 6, 1925

8. AGE: Years	Months	Days	If less than one day
20	10	15	hrs. min.

9. Birthplace: Lynchburg, Va.
(Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business

FATHER
12. Name: Robert Preston
13. Birthplace: Prospect, Va.

MOTHER
14. Maiden name: Janie ?
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26 1946 (month) (day) (year)
Cemetery or crematory: Lynchburg Va
Location: Campbell County
18. Funeral director: Mrs Lottie Gross
Address: 1408 Ashland Ave Baltimore

19. Jan. 21, 46 (Date rec'd by registrar) Alfred R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21, 1946 at 5:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15, 1944 to Jan. 21, 1946 and that I last saw her alive on Jan. 21, 1946

Immediate cause of death	DURATION
Tuberculosis of the Spine	June 6, 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 1-21-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00428

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 3 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 420 N. Eden Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM PRICE

3.(b) Social Security Number: 237-14-5485

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Pauline Price
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 5, 1917

8. AGE:	Years	Months	Days	If less than one day
	29	0	2	hrs. min.

9. Birthplace: Scotland Neck, N.C.
(Town, county, and state)
10. Usual occupation: Sprayer in defense plant
11. Industry or business

FATHER
12. Name: John Price
13. Birthplace: Scotland Neck, N.C.

MOTHER
14. Maiden name: May Jacobs
15. Birthplace: Scotland Neck, N.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-10-46 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: A. C.
18. Funeral director: Elroy O. Wilson
Address: 1010 Bentley ave

19. Jan. 7, 1946 (Date rec'd by registrar) Allen A. Swanblum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7, 1946 at 3:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4, 1945 to Jan. 7, 1946 and that I last saw him alive on Jan. 7, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed 1-7-46

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

00424

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Carroll

City or town rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yr., 8 mo., 10 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 16 yr., 8 mo., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)

State Maryland County .....

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Harry J. Reinfelder

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 29, 1912

8. AGE: Years	Months	Days	If less than one day
33	6	12	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name George Reinfelder

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Minnie H. Rohrman

15. Birthplace Baltimore, Maryland

16. Informant Springfield State Hosp. records

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-45 (month) (day) (year)

Cemetery or crematory Dutch Neck

Location North Ave

18. Funeral director John E. Miller Inc

Address 243 E. Oliver St

19. 1/12 (Date rec'd by registrar) 19 46 A. H. Bedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 19 46 at 3:40p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to Jan 11 19 46 and that I last saw him alive on January 11 19 46

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration, prior to Jan '46	
Due to	.....
.....	.....
Due to	.....
.....	.....
Other conditions Dementia precox, hebephrenic type	18 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert Bertrand May, M.D.

Springfield State Hospital M. D. or other

Address Sykesville, Maryland Date signed 1-11-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

00430

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:
County: Carroll
City or town: Middleburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Middleburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Jesse Reisler

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Reisler
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 8 - 1855

8. AGE:	Years	Months	Days	If less than one day
	90	2	29	hrs. min.

9. Birthplace: Frederick Co. Maryland (Town, county, and state)
10. Usual occupation: Hotel Proprietor
11. Industry or business: Retired

FATHER
12. Name: Thomas Reisler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Smith
15. Birthplace: Maryland

16. Informant: Jack Lynn
Address: Middleburg Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 10 - 1946 (month) (day) (year)
Cemetery or crematory: Mountain View Cemetery
Location: Union Bridge Maryland

18. Funeral director: D. D. Hafer & Son
Address: Union Bridge & New Windsor Rd

19. Jan. 8 1946 (Date rec'd by registrar) H. Eichenson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 1946 at 6.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6 1946, to Jan. 7 1946 and that I last saw him alive on Jan. 7 1946

Immediate cause of death	DURATION
(a) Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. D. Marsden M.D. M. D. or other
Address: Union Bridge Date signed: Jan. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00431

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs 4 mos 26 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 5 yrs 4 mos 26 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: Jennie Rosenberg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Harry Rosenberg

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15th 1904

8. AGE: Years 41 | Months 8 | Days 2 | If less than one day: hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At home

FATHER
12. Name: Joseph Brown
13. Birthplace: Russia

MOTHER
14. Maiden name: Sofia Malunsky
15. Birthplace: Russia

16. Informant: Mrs Elizabeth Kurland

Address: 1347 Reisterstown Rd Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 18, 1946 (month) (day) (year)

Cemetery or crematory: Hebrew Rondale

Location: Balto. md.

18. Funeral director: Jack Lewis Inc.

Address: 2160 Eutaw Place

19. Jan. 17 1946 (Date rec'd by registrar) A. Harry Weiss Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16th 1946 at 3-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 21st 1945 to Jan 16th 1946

and that I last saw her alive on Jan 16th 1946

	DURATION
Immediate cause of death:	
Bronchio Pneumonia	2wks
Due to: Influenza	2wks
Due to:	
Other conditions: Huntingtons Chorea	10yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed 1/16/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 mo.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Adam Clark Smith

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Sarah Alice Smith
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 7 1867

8. AGE: Years	Months	Days	If less than one day
78	3	16	hrs. min.

9. Birthplace: Freelands, Maryland (Town, county, and state)
10. Usual occupation: retired farmer
11. Industry or business:
FATHER 12. Name: Daniel Smith
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Walker
15. Birthplace: Maryland
16. Informant: G. Vernon Smith
Address: Hampstead Md.
17. [illegible] Burial (Burial, cremation, or removal—which?) Date thereof: Jan 25-1946 (month) (day) (year)
Cemetery or crematory: St Peters Balt Co Md.
Location: Millers Md RD#.
18. Funeral director: H.C. Tuttle
Address: Glen Rock Pa.
19. Jan. 24 1946 Mrs. W.P.S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1946, at 7 45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 1946, to January 23 1946 and that I last saw him alive on January 18 1946

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Arteriosclerotic Cardiac Renal	
vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Jacob E. Bunt M.D. M. D. or other
Address: Hampstead Md. Date signed 1-23-46

00433

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: L. Roberta Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Benjaminan M. Smith
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 20 - 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	3	14		

9. Birthplace: Frederick Co Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Amos V. Eyler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maria Lowers
15. Birthplace: Maryland

16. Informant: Mrs Thelma Anders
Address: Union Bridge Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan 6 - 1946 (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: Near Uniontown Maryland

18. Funeral director: D. D. Hartzler + Son
Address: Union Bridge + New Windsor Md

19. Jan. 6 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4 1946, at 7.45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1945, to Jan 4 1946, and that I last saw h.er alive on Jan 3 1946

Immediate cause of death	DURATION
Carcinoma of breast	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. H. Leys M. D. or other
Address: Union Bridge Date signed: 1-5-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00434

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 79 Penn. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alberta Catherine Stouch

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Joseph Stouch
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) March 29 - 1865

8. AGE:	Years	Months	Days	If less than one day
	80	9	26	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Home
11. Industry or business
FATHER 12. Name John Geiselman
FATHER 13. Birthplace Littlestown, Pa.
MOTHER 14. Maiden name Mary Garbaugh
MOTHER 15. Birthplace Littlestown, Pa.
16. Informant Mrs Leighton Byers
Address Ryderwood, Balto Co. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 28 - 1946 (month) (day) (year)
Cemetery or crematory Ryder Cemetery
Location Westminster, Md.
18. Funeral director H Bankard & Son
Address Westminster, Md.
19. 1/26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25. 1946, at 2:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 - 1946 to Jan 25 - 1946 and that I last saw h[illegible] alive on Jan 24 - 1946

Immediate cause of death	DURATION
Dilatation -	1 hr
Due to Chronic Myocarditis	2 yrs
Due to Chronic Bronchitis	10 yrs
Other conditions Uterine Fibroid -	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edna R. Fout M D
M. D. or other
Address Westminster Md Date signed 1-25-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01435

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 3 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 312 Worsley St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ROSA STREET

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 15, 1920

8. AGE:	Years	Months	Days	If less than one day
	25	3	24	hrs. min.

9. Birthplace: Crewe, Virginia (Town, county, and state)

10. Usual occupation: Worker in Sugar Factory

11. Industry or business

FATHER 12. Name: Sye Street

13. Birthplace: Virginia

MOTHER 14. Maiden name: Mary Oliver

15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 14 1946 (month) (day) (year)

Cemetery or crematory: Ship to Crewe, Va.

Location:

18. Funeral director: Raynor Sanders

Address: 1412 E. preston St.

19. Jan. 9 19 46 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9, 1946, at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1945 to Jan. 9, 1946 and that I last saw her alive on January 9, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed 1-9-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

★ 00426 Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Susan Lottey Walsh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: William Walsh.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 27 1870

8. AGE: Years 75 | Months 11 | Days 15 | If less than one day: hrs. min.

9. Birthplace: Manchester, Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: John Thomas Yingling
13. Birthplace: Manchester Md

MOTHER 14. Maiden name: Louisa Ickes
15. Birthplace: Union Mills Md.

16. Informant: Mrs. Walter Stephan
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-46 (month) (day) (year)
Cemetery or crematory: cemetery
Location: Manchester, Md

18. Funeral director: Jacob Winkler Sons
Address: Manchester Md.

19. Jan. 12 1946 M. D. W. P. S. Denver
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11 1946, at 7 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1945, to January 11 1946 and that I last saw h.. alive on January 10 1946

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to	
Due to	
Other conditions: Partial intestinal obstruction due To post operative adhesions (Include pregnancy within 3 months of death)	

Major findings of operations: —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Joseph E. Buck MD M. D. or other
Address: Hampstead Md. Date signed 1-11-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

00437

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs. 8 mo. 6 da.
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 16 yrs. 8 mo. 6 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 536 South Paca Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ANTONIA WALSKY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Martin Walsky
Address unknown 6.(c) If alive, give age unknown years
7. Birth date of deceased (mo., day, yr.) September 19, 1888

8. AGE: Years	Months	Days	If less than one day
57	9	4	....hrs. ....min.

9. Birthplace Russia (Town, county, and state)
10. Usual occupation housewife
11. Industry or business home

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden name Unknown
15. Birthplace Russia

16. Informant Hospital Records
Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 28/46 (month) (day) (year)
Cemetery or crematory New Cathedral Cem.
Location Edmondson Ave
18. Funeral director John A. Miller
Address 2334 Jefferson St.

19. Jan. 23 1946 C. Henry Lewis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23rd. 1946, at 8.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1929, to Jan 23 1946
and that I last saw her alive on Jan. 23 1946

Immediate cause of death	DURATION
Carcinoma of the sigmoid	1 yr.
Due to flexure of the colon	
Due to	
Other conditions Schizophrenia	19 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hans W. Rees M.D.
M. D. or other
Address Sykesville, Md. Date signed 1-23-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

00438

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85a

CERTIFICATE OF DEATH

Reg. Dist. No. 7d

1. PLACE OF DEATH:

County Carroll

City or town Taneytown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Fannie B. Wantz

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband ~~or wife~~ J. Thomas Wantz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 5, 1874

8. AGE: Years	Months	Days	If less than one day
71	6	14	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER 12. Name Samuel S. Rodkey

13. Birthplace Maryland

MOTHER 14. Maiden name Mary E. Nodel Fair

15. Birthplace Maryland

16. Informant J. Thomas Wantz

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 21, 1946 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Taneytown, Maryland

18. Funeral director C O Fuss & Son

Address Taneytown, Maryland

19. Jan 21, 1946 (Date rec'd by registrar) Athel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1946 at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Hood Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 1/19/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-2)

00439

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alice H. Warehime

3.(b) Social Security Number: C

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femail	White	Married

6.(b) Name of husband ~~or wife~~: Jacob W. Warehime
6.(c) If alive, give age: 81 years
7. Birth date of deceased (mo., day, yr.): Aug. 8. 1867

8. AGE: Years: 78 | Months: 5 | Days: 2 | If less than one day: ...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business
12. Name of father: Valentine Manchey
13. Birthplace of father: Maryland
14. Maiden name of mother: Henrietta Grumine
15. Birthplace of mother: Maryland
16. Informant: Jacob W. Warehime
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-13-46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Jacob Wantz & Son
Address: Manchester Md
19. Jan. 11 1946 Mrs. W. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10, 1946, at 7.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 3, 1946, to Jan 10, 1946
and that I last saw h...w alive on Jan. 9 1946

Immediate cause of death	DURATION
Septicaemia	7 da
Due to: Parotid Abscess	7 da
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jas. E. Bush M.D.
M. D. or other
Address: Hampstead Md Date signed 1/11/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

00440

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 yrs. 8 mo. 10 da.
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 19 yrs. 8 mo. 10 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1805 Whittmore Avenue (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LENA WEIBEL (Waibel)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

B.(b) Name of husband or wife (unknown) Weibel (Waibel)
unkn B.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Exact date unknown (1862)

8. AGE: Years	Months	Days	If less than one day
84			hrs. min.

9. Birthplace Maryland. (town unknown) (Town, county, and state)
10. Usual occupation none
11. Industry or business none
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
18. Informant Hospital Records
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30 1946 (month) (day) (year)
Cemetery or crematory Western Cemetery
Location Baltimore, Md.
18. Funeral director Harry W. Wiltshe
Address Dolbin & Edmondston
19. Jan. 28 1946 (Date rec'd by registrar) C. Harry Eberly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1946 at 3.40 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1926 to Jan. 27 1946
and that I last saw her alive on January 26, 1946

Immediate cause of death	DURATION
Gangrene (arteriosclerotic) of the left foot	1 mo.
Due to	
Due to	
Other conditions General arteriosclerosis	20 year

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D.
M. D. or other
Address Sykesville Md. Date signed 1-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00441

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 28 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 712 Aisquith Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ALBERT WILSON

3.(b) Social Security Number: 719-18-5707

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10, 1910

8. AGE: Years	Months	Days	If less than one day
35	6	12	hrs. min.

9. Birthplace: Cumberland County, N.C. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Bettie ?
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: 1/25/46 (month) (day) (year)
Cemetery or crematory: Removed from Balto. City
Location: morgue to Dunn, N. C.
18. by Funeral director: O. F. Payton
Address: Dunn, N. C.

19. Jan. 22, 1946 (Date rec'd by registrar) Albert R. Strickland Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22, 1946, at 5:00P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 24, 1945, to Jan. 22, 1946 and that I last saw him alive on Jan. 22, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	August 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 1-22-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Item 17: From D.D. Hartzler, filmed 3-12-48 G1142

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Elgar Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Effie Irene Wilson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: J. Calvin Wilson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 25 - 1901

8. AGE:	Years	Months	Days	If less than one day
	44	8	24	..... hrs. ..... min.

9. Birthplace: Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Taylor Grimes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah E. Lippy
15. Birthplace: Maryland

16. Informant: J. Calvin Wilson

Address: Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-22-46 (month) (day) (year)

Cemetery or crematory: Ebenezer Lutheran Cemetery

Location: Uniontown Maryland

18. Funeral director: D.D. Hartzler & Son

Address: Union Bridge & New Windsor Md

19. Jan. 21, 1946 (Date rec'd by registrar) W. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19, 1946, at 11.20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17, 1946, to Jan 19, 1946, and that I last saw her alive on Jan 19, 1946

Immediate cause of death	DURATION
Pneumonia	
Due to: Lungs and Chest	
Due to: Pneumonia Left Chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Mason M.D. M. D. or other

Address: Johnsville Date signed: Jan 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

Reg. Dist. No. 00481

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Back Hall
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Edmund Yingling

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs Ada Yingling

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 12 - 1867

8. AGE: Years	Months	Days	If less than one day
78	4	29	..... hrs. ..... min.

9. Birthplace: Carroll County Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: Edmund Yingling
13. Birthplace: Maryland

MOTHER
14. Maiden name: Agnes Arntz
15. Birthplace: Penna.

16. Informant: Mrs Ada Yingling
Address: Union Bridge Md - R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan - 14 1946 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Uniontown Maryland

18. Funeral director: D. D. Hartle & Son

Address: Union Bridge & New Windsor Md

19. Jan. 12 1946 (Date rec'd by registrar) E Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11 1946, at 9.15 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1945, to Jan 11 1946 and that I last saw him alive on Jan 11 1946

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. N. Legg M. D. or other

Address: Union Bridge Date signed 1-12-46